

ORIGINAL

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In The Matter of Charges and)

Complaint Against)

STELLA YI CHOU, M.D.,)

Respondent.)

Case No. 08-29655-1

AUG 17 2010

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

THIRD AMENDED COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners, currently composed of Charles N. Held, M.D., Chairman, Theodore Berndt, M.D., Member, and Ms. Valerie Clark, BSN, RHU, LUTCF, Member, by and through Lyn E. Beggs, General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Stella Yi Chou, M.D., hereinafter referred to as Dr. Chou, has violated the provisions of NRS Chapter 630, hereby issues its Third Amended Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Dr. Chou was licensed in active status to practice medicine in the State of Nevada (license no. 11344), at all times alleged herein, was so licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Valley Eye Center, 2931 Tenaya Way, Suite 204, in Las Vegas, Nevada originally opened in approximately August 2006 as "Clinique Optique". On or about October 5, 2006, Valley Eye Center began providing refractive surgery to correct refractive errors of the eye, more commonly known as "Lasik." The practice of Valley Eye Center was limited exclusively to the providing of Lasik and performed fairly high volumes of such procedures.

3. The owner and administrator of the facility was purported to be Anamika Jain, M.D. Dr. Anamika Jain is married to Vikas Jain. Dr. Anamika Jain is not an ophthalmologist. Dr. Anamika Jain's specialty is shown in the Board's records to be Rehabilitation Medicine.

4. Vikas Jain had been licensed as a physician, specializing in ophthalmology, in Ohio, New York, and Florida. On November 14, 2005, the State Medical Board of Ohio revoked Vikas Jain's license to practice medicine. The Ohio Board's order found, among other things, that Vikas Jain had committed ophthalmological malpractice upon 22 specific patients, resultant from his failure to properly preoperatively assess the patients, resulting in ophthalmological surgical errors that caused harm to the 22 patients. Subsequent to the revocation of his license by the State Medical Board of Ohio, the medical licenses of Vikas Jain in New York and Florida were surrendered after both states filed disciplinary proceedings against him based upon the Ohio action. Vikas Jain has no active license to practice medicine in any state in the United States. Vikas Jain never applied for a license to practice medicine in Nevada.

5. In October 2006, Dr. Chou began performing refractive eye surgeries at Valley Eye Center. Dr. Chou lives in Utah and never maintained a residence or presence in Nevada except that she performed Lasik surgeries at Valley Eye Center. Dr. Chou was not employed by Valley Eye Center; instead, Dr. Chou was an independent contractor, placed at Valley Eye Center through CompHealth, a physician recruiting and temporary placement service based out of Salt Lake City, UT. Dr. Chou was not at Valley Eye Center on a fulltime basis, rather she would fly into Las Vegas at regularly scheduled intervals to perform Lasik procedures and provide some post-operative care.

6. During the period of time that Dr. Chou performed Lasik surgeries at Valley Eye Center, the normal practice was that patients were seen at Valley Eye Center for pre-operative measurements and assessments in preparation for Lasik and to determine if patients were good candidates for the procedure and would then be scheduled for a Lasik procedure with Dr. Chou. From October 2006 to March 2007, Dr. Chou performed Lasik surgeries at Valley Eye Center. During that time period there was no licensed ophthalmologist or optometrist on the premises to perform pre-operative evaluations or assessments in her absence. There is no evidence to indicate that Dr. Chou was aware of this fact, however Dr. Chou conducted no personal investigation to assure herself that such licensed personnel were actually on-site and available to patients. Pre-operative evaluations were allegedly conducted by non-licensed individuals, medical assistants, known as "techs" and although many pre-operative measurements and assessments could be

preformed by these medical assistants at the direction of a licensed ophthalmologist or optometrist, some of the pre-operative evaluations could only be performed by a licensed optometrist or ophthalmologist.

7. Between March 2007 and May 2008 while Dr. Chou was at Valley Eye Center, Dr. Elise Millie, a licensed optometrist was on the staff of Valley Eye Center and did perform some pre-operative evaluations and assessments of potential Lasik patients, and if appropriate would schedule patients for Lasik surgery on days that Dr. Chou would be performing surgeries at Valley Eye Center.

8. During the time that Dr. Chou was at Valley Eye Center, on information and belief, many of the preoperative examinations, measurements and assessments were completed by Vikas Jain who was known to sometimes represent himself to patients as "Dr. Ken." Vikas Jain would perform preoperative assessments, measurements and examinations of patients' eyes, in part to determine their candidacy for Lasik surgery. Dr. Chou was not present at Valley Eye Center when medical assistants performed measurements or when Vikas Jain performed medical examinations and/or assessments on patients' eyes, and she exerted no supervisory oversight or control over the work of Vikas Jain or the medical assistants. There is no evidence to indicate that Dr. Chou had any knowledge or was informed that Vikas Jain was performing these tasks.

9. Dr. Chou would normally fly into Las Vegas the evening before surgeries were to be performed. Upon arrival in Las Vegas, Dr. Chou would be presented with a number of files for the surgeries that were scheduled for the following days and she would review the information in the files. Many of the preoperative assessments, measurements and evaluations contained in the patient files would have been performed by medical assistants and/or Vikas Jain.

10. The following day and sometimes for multiple days, Dr. Chou would perform Lasik eye surgeries using a Nidek EC-5000 machine leased by Valley Eye Center. Nidek machines require the use of precise measurements to assure the proper outcome of the surgery and may not be used on dilated eyes.

11. Dr. Chou would meet with groups of patients to discuss general informed consent issues, and with individuals if they had specific problems to discuss. However, Dr. Chou did not

1 inquire during any of her meetings with patients as to who had performed the preoperative work-up
2 prior to the patients being seen by Dr. Chou.

3 12. Pursuant to this normal mode of practice, Dr. Chou performed Lasik surgery upon the
4 eyes of Patients A, B, C, D.

5 **Count I**

6 13. Patient A had double vision and wore glasses with prisms. On or about February 7,
7 2007, Patient A presented to Valley Eye Center for Lasik surgery which was performed by Dr. Chou
8 in the manner described above.

9 14. NAC 630.040 defines malpractice as failure of a physician, in treating a patient, to
10 use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

11 15. NRS 630.301(4) provides that malpractice is grounds for initiating disciplinary action
12 against a licensee.

13 16. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used
14 under similar circumstances, by physicians in good standing practicing ophthalmology in Nevada
15 when she performed the Lasik surgery upon Patient A without exercising adequate due diligence
16 to assure that preoperative exams were being conducted by qualified persons.

17 17. Dr. Chou's treatment of Patient A as alleged constitutes a violation of
18 NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

19 **Count II**

20 18. On or about January 12, 2007, Patient B presented to Valley Eye Center for Lasik
21 surgery which was performed by Dr. Chou in the manner described above.

22 19. Nevada Administrative Code section 630.040 defines malpractice as "the failure of a
23 physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under
24 similar circumstances."

25 20. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for
26 initiating discipline against a licensee.

27 21. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used
28 under similar circumstances, by physicians in good standing practicing ophthalmology in Nevada

1 when she performed the Lasik surgery upon Patient B without exercising adequate due diligence to
2 assure that preoperative exams were being conducted by qualified persons.

3 22. Dr. Chou's treatment of Patient B as alleged constitutes a violation of
4 NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

5 **Count III**

6 23. On or about January 12, 2007, Patient C underwent Lasik surgery to correct
7 nearsightedness at Valley Eye Center. The procedure was performed by Dr. Chou pursuant to the
8 procedures set forth above.

9 24. Nevada Administrative Code section 630.040 defines malpractice as "the failure of a
10 physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under
11 similar circumstances."

12 25. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for
13 initiating discipline against a licensee.

14 26. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used
15 under similar circumstances, by physicians in good standing practicing ophthalmology in Nevada
16 when she performed the Lasik surgery upon Patient C without exercising adequate due diligence to
17 assure that preoperative exams were being conducted by qualified persons.

18 27. Dr. Chou's treatment of Patient C as alleged constitutes a violation of
19 NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

20 **Count IV**

21 28. On or about March 9, 2007, Patient D presented to Valley Eye Center for Lasik
22 surgery. The procedure was performed by Dr. Chou pursuant to the procedures set forth above.

23 29. Nevada Administrative Code section 630.040 defines malpractice as "the failure of a
24 physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under
25 similar circumstances."

26 30. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for
27 initiating discipline against a licensee.

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32. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient D without exercising adequate due diligence to assure that preoperative exams were being conducted by qualified persons.

Count V

35. NAC 630.230(1)(i) provides that a physician shall not fail to provide adequate supervision of a medical assistant who is employed or supervised by the physician or physician assistant.

Count VI

38. Dr. Chou's acts as averred in this Third Amended Complaint show a continual failure from October 2006 to March 2007 to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same

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1 specialty or field while engaged in practice at Valley Eye Center for which Dr. Chou is subject to
2 discipline.

3 **WHEREFORE**, the Investigative Committee prays:

4 1. That the Nevada State Board of Medical Examiners fix a time and place for a
5 formal hearing;

6 2. That the Nevada State Board of Medical Examiners gives Dr. Chou notice of the
7 charges herein against her, the time and place set for the hearing, and the possible sanctions
8 against her;


9 3. That the Nevada State Board of Medical Examiners determine what sanctions it
10 determines to impose for the violation or violations committed by Dr. Chou; and

11 4. That the Nevada State Board of Medical Examiners make, issue and serve on
12 Dr. Chou its findings of facts, conclusions of law and order, in writing, that includes the sanctions
13 imposed; and

14 5. That the Nevada State Board of Medical Examiners take such other and further
15 action as may be just and proper in these premises.

16 DATED this 17th day of August, 2010.

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18 THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

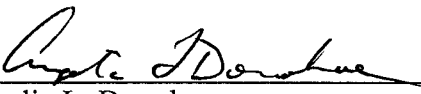
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20 By: 
21 Lynn E. Beggs
22 General Counsel and Attorney for the Investigative Committee
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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 17th day of August 2010; I served a file copy of the Third Amended Complaint, Third Amended Patient Designation and Original Settlement, Waiver and Consent Agreement, by mailing via Fed-Ex to the following:

John H. Cotton, Esq.
Katherine L. Turpen, Esq.
2300 W. Sahara Ave., Ste. 420
Las Vegas, NV 89102

Dated this 17th day of August 2010.



Angelia L. Donohoe
Legal Assistant